STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085048	A. BUILDING _____ B. WING _____	05/26/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CADIA REHABILITATION CAPITOL	1225 WALKER ROAD DOVER, DE 19904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced annual and complaint survey was conducted at this facility from May 18, 2017 through May 26, 2017. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred twelve (112). The survey sample totaled forty-one (41). Abbreviations used in this report are as follows: NHA - Nursing Home Administrator; DON - Director of Nursing; RN - Registered Nurse; LPN - Licensed Practical Nurse; MD-medical doctor; UM - Unit Manager; MDS - Minimum Data Set-standardized assessment forms used in nursing homes; CNA - Certified Nurse's Aide; RNAC - Registered Nurse Assessment Coordinator; ADL - Activities of Daily Living, such as bathing and dressing; eMAR - Electronic Medication Administration Record; Cognition-thinking, memory; Cognitively Impaired - mental decline including losing the ability to understand, talk or write; Dementia - brain disorder with memory loss, poor judgement, personality changes and disorientation; Diabetes-high sugar levels in the blood; Fingerstick - test to determine blood sugar (glucose); Insulin - injected medication to control blood sugar;	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 Hypoglycemia-low blood sugar levels; Oxycodone - pain medication often used for more severe pain; Pain Scale - rating pain severity on a 0 to 10 scale with 0 meaning no pain and 10 meaning the worst pain; Tylenol-pain/fever medication; Tuberculosis-infectious disease of the lungs; 1:1- one activity staff person engaging in an activity with one resident; %-percentage; PRN - as needed.	F 000		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to provide care and services in a manner that promoted dignity. Findings include: 1. During random observation on 5/18/17 at 7:47 AM on the Holly unit E8 (CNA) was overheard saying "this is the feeder cart", referring to the cart of meal trays on the unit. Residents were sitting in the dining area.[The term feeder referred to residents that required assistance with eating.] 2. During random observation on 5/18/17 between 7:47 AM and 8:05 AM on the Holly unit E13 (CNA) was observed serving and setting up	F 241	F241 1. a.) No residents were negatively impacted by this deficient practice. 1. b.) All residents who require assistance with feeding have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #1c. 1. c.) The facility will conduct a focus review of all like residents. The facility will conduct focused education for licensed nursing staff and certified nursing assistants on proper terminology regarding residents who require	7/10/17

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F 241	Continued From page 2 trays to several resident while wearing gloves. There was no indication (need to touch food) for the use of gloves. 3. During a random observation on 5/18/17 from 8:10 AM to 8:40 AM E14 (Dietary Aide) was observed serving residents breakfast while wearing gloves. There was no indication for the use of gloves. 4. During stage I resident interviews on 5/18/17 at 11:08 AM E15 (CNA) entered R19's room without requesting or receiving permission to enter. 5. During a dining observation on 5/18/17 at 8:14 AM E3 (ADON) stated to E16 (CNA) that she put R11's "tray on the top [of the meal cart] she's a "feeder". 6. 5/18/17 - A random lunch observation on Holly (dementia) unit discovered staff not asking permission or stating the purpose when placing clothing protectors / bibs on the following five residents between 12:07 PM - 12:15 PM: - E5 (LPN) placed on R109 who needed to be fed by staff. - E6 (CNA) placed on R32 and R25 who required extensive assistance with eating. - E7 (CNA) placed on R47 who eats independently. - E8 (CNA) placed on R38 who is totally dependent on staff for eating. Review of the care plans for all five residents found no entries that included the use of the clothing protector / bib as an intervention. 7. Random observations on the Holly unit revealed staff entered resident's rooms without	F 241	assistance with feeding and in regards to dignity and respect of individuality of residents. 1. d.) The Director of Nursing (DON)/designee will audit all units who are noted to have residents who require assistance with feeding to assess for proper staff terminology. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. 2. a.) No residents were negatively impacted by this deficient practice. 2. b.) All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #2c. 2. c.) The facility will conduct a focus review of all residents. The facility will conduct focused education for CNAs on proper technique of serving meals r/t meal distribution and tray set up. 2. d.) The Director of Nursing (DON)/designee will audit resident dining to assess for proper tray distribution and tray set up. The audit will be conducted daily until 100% compliance is achieved.	

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F 241	Continued From page 3 knocking and/or waiting for permission to enter while residents were in their room: - 5/18/17 (9:25 - 9:26 AM): E9 (Central Supply) knocked and entered R126's room without speaking. E8 (CNA) entered SS1's room without knocking and stated the resident's first name while entering the room. - 5/21/17 (9:23 AM - 9:40 AM): E9 knocked, said "Good morning" and immediately entered R126's room. E9 knocked and immediately entered R38's room without speaking. E9 knocked, said "Good morning" and immediately entered SS2's room. E9 knocked, said "Good morning" and immediately entered R86's room. E9 knocked and immediately entered R25's room without speaking. - 5/22/17 (9:30 - 9:33 AM): E9 knocked, said "Morning" and immediately entered SS3's room. E9 knocked, said "Supplies" and immediately entered SS1's room. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/26/17 at 11:00 AM.	F 241	Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. 3. a.) No residents were negatively impacted by this deficient practice. 3. b.) All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #3c. 3. c.) The facility will conduct a focus review of all residents. The facility will conduct focused education for Dietary Aides on proper technique of serving meals r/t meal distribution. 3. d.) The Director of Nursing (DON)/designee will audit resident breakfast dining to assess for proper meal distribution. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and	

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F 241	Continued From page 4	F 241	discussed at the facility QA Meeting. 4. a.) R19 was not negatively impacted by this deficient practice. 4. b.) All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #4c. 4. c.) The facility will conduct focused education for certified nursing assistants on proper procedure for entering a resident's room. 4. d.) The Director of Nursing (DON)/designee will audit of compliance to Dignity and Respect of Individuality r/t proper procedure of entering a residents room. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. 5. a.) R11 was not negatively impacted by this deficient practice. 5. b.) All residents who require assistance with feeding have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #5c.	

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F 241	Continued From page 5	F 241	5. c.) The facility will conduct a focus review of all like residents. The facility will conduct focused education for licensed nursing staff and certified nursing assistants on proper terminology regarding residents who require assistance with feeding and in regards to dignity and respect of individuality of residents. 5. d.) The Director of Nursing (DON)/designee will audit all units who are noted to have residents who require assistance with feeding to assess for proper staff terminology. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. 6. a.) R109, R32, R25, R47, and R38 were not negatively impacted by this deficient practice. 6. b.) All residents who require the use of clothing protectors during dining of lunch meal have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #6c. 6. c.) The facility will conduct a focus	

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F 241	Continued From page 6	F 241	review of all like residents. The facility will conduct focused education for licensed nursing staff and certified nursing assistants on proper procedure for donning residents with clothing protectors. 6. d.) The Director of Nursing (DON)/designee will audit all residents who require use of clothing protectors during dining of lunch meal to assess for proper staff procedure of donning resident with clothing protector. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. 7. a.) R126, SS1, R38, SS2, R86, R25, and SS3 were not negatively impacted by this deficient practice. 7. b.) All residents have the potential to be affected by this deficient practice. Future residents will be protected from this deficient practice by taking the corrective actions outlined below in #7c. 7. c.) The facility will conduct focused education for certified nursing assistants and Central Supply Staff on proper procedure for entering a resident's room. 7. d.) The Director of Nursing (DON)/designee will audit of compliance	

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F 241	Continued From page 7	F 241	to Dignity and Respect of Individuality r/t proper procedure of entering a residents room. The audit will be conducted daily until 100% compliance is achieved. Then, the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then, the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of other facility documentation the facility failed to ensure resident choices were respected for one	F 242	F242 1. R227 was not negatively impacted by the cited deficient practice. Facility staff	7/10/17

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F 242	Continued From page 8 (R227) out of 41 sampled residents. Findings include: Review of R227's clinical record revealed: 4/15/17 - An admission MDS assessment in the preferences section completed for R227 indicated that the resident felt it was somewhat important to choose between tub bath and showers. R227 was cognitively intact. During a stage I resident interview on 5/19/17 at 11:18 AM R227 answered "No" when asked "Do you choose whether you take a shower, tub, or bed bath?" R227 further explained that she had "not had a shower since she has been at the facility 4/8/17." R227 reported she was told she would be given a shower on day shift but no one had told her yet and she "asked but I think they forgot," R227 then reported that therapy staff said they may assist her. Review of R227's Point of Care history which documents showers received by resident showed R227 did not receive a shower until 5/24/17. During an interview on 5/25/17 at 10:45 AM with E24 (RN) it was reported that R227 was scheduled to receive showers on Tuesdays and Fridays, and that showers were assigned by the resident's room number. During an interview on 5/25/17 at 10:49 AM with E23 (LPN) it was confirmed that R227 received one shower since her 4/8/17 admission and that was on 5/25/17. E23 stated that R227 "wanted to get a shower but had wounds." E23 confirmed that there was no documentation stating R227 could not have a shower.	F 242	discussed with R227 her preferences for showers and the schedule was adjusted. 2. All residents could be affected by the cited deficient practice. Residents will be protected by taking the corrective actions as outlined below in #3. 3. The facility will conduct a focus review of all like residents who do not have a diagnosis of dementia or Alzheimer's to identify if they are satisfied with their current shower schedule. The DON/designee will educate licensed nursing staff on resident preferences and incorporating them into the plan of care. 4. The Director of Nursing/designee will audit compliance to for new admissions to verify that they were provided an opportunity for input for their shower schedule. The audit will be conducted daily until 100% compliance is achieved. Then the audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	

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F 242	Continued From page 9 During an interview on 5/25/17 at 10:57 AM with E22 (CNA) the CNA shower documentation for R227 was reviewed and E22 confirmed that the resident had not received any showers or tub baths during her admission. E22 stated that R227 had not received a shower because of wounds to her back and chest area. E22 confirmed that nursing staff nor plan of care documented that R227 was not to receive showers due to wounds. E22 reports she did offer showers, however E22 did not document refusals on the shower record. When asked if R227 refused showers E22 stated "kind of" then E22 confirmed s/he did not follow up with a nurse to see whether R227 could have a shower or not. During an interview on 5/25/17 at 11:14 AM with R227 it was reported that the facility "told me I could shower, but never given a time or told me when I would be taken. Finally, my Occupational Therapist took me and I got my first shower yesterday." When asked if anyone offered her a shower R227 stated "No" and explained she "assumed" it was because of her wounds. R227 then stated "I asked one time about receiving a shower, they said they would look into but I never heard anything about it." During an interview on 5/25/17 at 11:21 AM with E18 (RN, UM) it was reported that the facility's system for assessing resident preferences was to ask the resident upon admission and incorporate responses into their plan of care. E18 then confirmed that R227 was not restricted from receiving showers and that refusals of showers should be documented in the progress notes or CNA documentation.	F 242		

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F 242	Continued From page 10 During an interview on 5/25/17 at 11:25 AM with E19 (CNA) it was confirmed that R227 did not receive a shower when assigned to E19 and stated she "does not remember" if a shower was offered and answered "no" for any reason the shower was not given. During an interview on 5/25/17 at 11:30 AM with E21 (CNA) it was confirmed that R227 received no showers on days E21 was assigned to care for R227, when asked why E21 stated "I don't know." R227 was admitted on 4/8/17 and expressed wanting to receive a shower and shower schedule. R227 did not receive a shower at the facility until 5/24/17 and still was not asked what her preference for showers related to scheduling and frequency. The facility failed to ensure that R227 received her preference for showers, failed to assess that preference, and failed to provide evidence that R227 was prohibited from showers due to wounds. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/26/17 at 11:00 AM.	F 242		
F 244 SS=B	483.10(f)(5)(iv)(A)(B) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their	F 244		7/10/17

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F 244	Continued From page 11 response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documentation it was determined the facility failed to respond promptly upon requests from the resident council. Findings include: August 2016 - April 2017 - Review of Resident Council Meeting minutes documented the council requested that the bulletin boards and artwork be rehung in the activity room in August, September, October, November, December and January. The facility provided no response to the repeated requests. - December 2016 minutes documented the new Activities Director starts the following week. - January 2017 minutes recorded E10 (Activity Director) to follow up with E1 (NHA) about which department head to address the residents' concern. - February 2017 minutes indicated the bulletin board was up and in use. During an interview with R65 (Resident Council President) on 5/25/16 around 10:00 AM R65 stated that two bulletin boards in the activity room were removed when the wallpaper was put up. "We asked for them to be returned for months. They threw everything out I guess. They said they had to get new ones." R65 said that E10 "bought the new bulletin boards" him/herself. During an interview with E10 on 5/25/17 at 11:00 AM, E10 confirmed s/he started at the facility in	F 244	F244 1. R65 was not negatively impacted by the cited deficient practice. A bulletin board was installed in the activity room for resident use. 2. The members of resident council could be affected by the cited deficient practice. Residents will be protected by taking the corrective actions as outlined below in #3. 3. The Activity Director will utilize a concern form for resident council meetings to facilitate communication with resident council on how their concerns/recommendations were addressed the will be reviewed at the next Resident Council meeting. 4. The Activity Director/designee will audit compliance to utilization of the concern/recommendation forms. The audit will be completed monthly until 100% compliance is achieved for three consecutive audits. When compliance is achieved the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	

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F 244	Continued From page 12 December, 2016 and discovered the residents had been asking for the bulletin boards and art work to be replaced in the activity room since last summer. E10 stated that s/he purchased the bulletin board since the facility had not responded to the request. "It is not as big as they wanted," but at least they have one. During an interview with E1 on 5/25/17 at 1:55 PM to determine how resident council concerns or grievances are addressed, E1 said that E10 would do the concern form and go to the department head, get resolution and present it at the next meeting. When asked when the activity room renovation was completed, E1 responded "after I started here" [September 2016]. E11 (Corporate Nurse) who was in attendance, said it was old and was "damaged during the renovation" and confirmed the renovation was finished by September/October. E1 said s/he attended the council meeting in October and started working on it [replacing the bulletin board] then. When the surveyor stated it's concerning that the issue was brought up in August, September, October, November, December and January and did not appear that there was a resolution, E1 offered no response. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/26/17 at 11:00 AM.	F 244		
F 248 SS=D	483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing	F 248		7/10/17

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F 248	Continued From page 13 program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide activities according to the comprehensive assessment and plan of care for two (R136 and R128) out of 41 sampled residents. Findings include: 1. Review of R136's clinical record revealed: 12/5/14 - Care plan for Activities (last reviewed 1/19/17) included the goal to participate in groups of interest once a week, receive 1:1 (one-on-one) visits twice a week and complete independent activities of interest twice a week. Interventions: invite and offer escort to groups of interest: catholic spiritual groups, games, trivia/discussion groups, big band music, dancing and outdoor groups. Read to resident as desired and available. 1/16/17 - Annual MDS documented activity preferences section was completed with the spouse as the resident is severely cognitively impaired. It was very important for the resident to listen to music, participate in religious services/practices and somewhat important to do things with groups of people, do favorite activities and go outside to get fresh air in good weather. August 2016 - May 2017 - Review of paper	F 248	F248 A. Resident 136 1. R136 was not negatively impacted by the cited deficient practice. R136 receives visits from their spouse on a daily basis. 2. All residents with scheduled 1:1 visits could be affected by the cited deficient practice. Residents who have a plan of care to include 1:1 visits will be protected by the cited deficient practice by taking the corrective the corrective actions outlined in #3. 3. The facility will conduct a focus review of all residents identified as requiring 1:1 visits. The comprehensive assessment will be updated as warranted to reflect current programming, including family and friends interactions to meet the resident's needs. 4. The Activity Director/designee will audit all residents with a plan of care for 1:1 visits for meeting the activities plan of care goals. The audit will be conducted weekly until 100% compliance is achieved. Then the audit will be conducted every other week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100%	

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F 248	Continued From page 14 activity logs documenting participation in activities, including 1:1 provided by activity staff, revealed that out of the 42 weeks, there were only twelve [12] weeks when the resident received a 1:1 visit twice a week. R136 received 1:1 visits once a week on eleven weeks and no 1:1 visits for 19 weeks. During an interview with E4 (LPN, UM) on 5/24/17 at 2:00 PM, E4 stated that the resident had "changed over the past few months." R136 used to watch TV and won't sit at the table for activities. R136 would walk around and observe from a distance. At times s/he would give a trivia answer. R136 likes to have books read to him/her. During an interview with E10 (Activity Director) on 5/25/17 at 10:27 AM when asked how activity aides were aware of each resident's activity goals, E10 stated s/he reviews their interests, abilities, goals, frequency of room visits, activity participation after the assessment is completed. The surveyor reviewed R136's activity logs in reference to receiving 1:1 twice weekly and E10 confirmed that R136 did not receive (or was offered) 1:1 visits as per the care plan. 2. Review of R128's clinical record revealed: 12/19/16 (reviewed/revised) - Care Plan for activities included goals to receive 1:1 visits twice a week and to attend group activities three times a week, with an approach of being invited and offered escort to groups of interest. 9/23/16 - Quarterly care plan review Activity note by E17 (former Activity Director) stated that R128 did not attend structured groups. Continue Care	F 248	compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting. B. Resident 128 1. R128 was not negatively impacted by the cited deficient practice. R128 regularly receives 1:1 visits with her family. 2. All residents with scheduled 1:1 visits could be affected by the cited deficient practice. Residents who have a plan of care to include 1:1 visits will be protected by the cited deficient practice by taking the corrective the corrective actions outlined in #3. 3. The facility will conduct a focus review of all residents identified as requiring 1:1 visits. The comprehensive assessment will be updated as warranted to reflect current programming, including family and friends interactions to meet the resident's needs. 4. The Activity Director/designee will audit all residents with a plan of care for 1:1 visits for meeting the activities plan of care goals. The audit will be conducted weekly until 100% compliance is achieved. Then the audit will be conducted every other week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered resolved. Results of the audits will be presented and discussed at the facility QA meeting.	

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F 248	Continued From page 15 Plan goals and approaches. 3/14/17 - Quarterly activity note by E10 documented that R128 continued to decline all invitations to group activities. Continue with POC (plan of care). March - May 2017 - Activity Logs for R128 reveal that the goal of three group activities a week was met zero times out of 11 weeks. R128 was invited and refused attendance to group activities 7 out of 11 weeks. R128 participated in two one-on-one visits 2 out of 11 weeks, one 1:1 visit 6 out of 11 weeks and no 1:1 visits 3 out of 11 weeks. In addition 1:1 visits were offered and declined by R128 two out of 11 weeks. 5/24/17 at 9:08 AM - During an interview E10 confirmed that R128 does not go to group activities, even when personally invited. E10 explained that R128 is on the room visit list to receive 1:1 visits due to her disinterest in group activities. 5/25/17 at 10:26 AM - During an interview E10 explained that a newly admitted resident received an activity assessment that is used to develop the resident's Care Plan. There are residents who have had a change of interests since their initial assessments and E10 stated that s/he was aware that assessments need to be updated. E10 confirmed that R128 was to receive more 1:1 visits than the resident had been receiving. Record review revealed that R128 has not regularly attended group activities for more than two quarters however, a new assessment to meet resident needs was not conducted.	F 248		

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F 248	Continued From page 16 These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/26/17 at 11:00 AM.	F 248		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must	F 272		7/10/17

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F 272	Continued From page 17 include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the comprehensive assessment was not accurate in the area of dental assessment for one (R160) out of 41 sampled residents. Findings include: Review of R160's clinical record revealed: 8/25/16 - Admission MDS assessment documented R160 had no natural teeth. 5/18/17 (12:59 PM) - During stage 1 of the survey R160 was observed to have natural teeth but was missing several upper and lower teeth. 5/24/17 (9:00 AM) - R160 denied mouth pain. During an interview with E4 (LPN, UM) on 5/24/17 at 9:10 AM, E4 confirmed R160 was "missing some teeth." The resident "came in with missing teeth" and had not seen a dentist since she was not having issues. During an interview with E12 (RNAC) on 5/24/17 around 11:50 AM, E12 confirmed the error stating	F 272	F272 1. R160 was not negatively impacted by the cited deficient practice. The comprehensive assessment for R160 was corrected. 2. All new residents have the potential to be affected by the cited deficient practice. Future residents will be protected from this cited deficient practice by taking the corrective actions outlined in #3 3. The facility will conduct a focus review of all residents admitted in the past 30 days to verify findings cited in the resident's comprehensive assessment, 4. The DON/designee will audit residents admitted since the survey completion date for accuracy of the initial assessment. The audit will be conducted weekly until 100% compliance is achieved. Then the audit will be conducted every other week until 100% compliance is achieved for three consecutive audits. Then, another audit will be conducted in one month. If 100% compliance is achieved, the cited deficient practice will be considered	

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F 272	Continued From page 18 that R160 was combative when the assessment was completed. E12 stated that a correction was made. This finding was reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/26/17 at 11:00 AM.	F 272	resolved. Results of the audits will be presented and discussed at the facility QA meeting.	
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that	F 309		7/10/17

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F 309	Continued From page 19 residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to provide care and services for two (R110 and R47) out of 41 sampled residents by failing to follow physicians' orders for withholding insulin and failing assess pain severity before and/or after PRN pain medication. Findings include: 1. Diabetes Management Review of R110's clinical record revealed: 12/10/14 - Physicians' order included fingerstick blood sugar (glucose) before meals and bedtime; Call physician if less than 60 or greater than 500. 12/16/14 - Care plan for Diabetes (last reviewed 3/24/17) included the interventions to administer medications; and fingersticks as ordered, report abnormal ranges to MD as indicated. Physicians' orders for insulin to control R110's blood sugar included: - 5/12/16: Lantus (long acting insulin) to be given in the evening (with no parameter for withholding). - 6/22/16: Humalog (short acting insulin) to be given three times a day after meals with parameter to only hold if blood sugar less than 60 and if patient eats less than 25% of meal. 3/13/17 - Quarterly MDS Assessment documented R110 had severe cognitive	F 309	F309 A. Resident 110 1. R110 was not negatively affected by the cited deficient practice. The physician was contacted about the insulin doses that were held and the episodes where blood sugar wasn't treated per facility policy. 2. All residents who are diabetic and have insulin parameters have the potential to be affected by the cited deficient practice. Future residents will be protected from the cited deficient practice by taking the corrective actions outlined below in #3. 3. The facility will conduct a focused review of all like residents who are diabetic with insulin parameters. The DON/designee will educate licensed nurses on the adherence to ordered medication parameters, physician notification of held medications, and the clinical documentation of resident changes. 4. The DON/designee will audit all diabetic residents with ordered insulin parameters to hold. The audit will be conducted daily until 100% compliance is achieved. The audit will be conducted three times a week until 100% compliance is achieved	

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F 309	Continued From page 20 impairment and diabetes. February 2017 - May 2017 - Review of R110's eMARs and progress notes discovered 43 doses of insulin were held but should have been administered: A. E20 (LPN) held Humalog insulin 40 times even though the resident ate over 25% of the meal and the blood sugar was not less than 60. There were no corresponding progress (nurses') notes in the record. - March 1, 2, 4, 5, 9, 10, 14, 15, 16, 19, 22, 28 and 29 (breakfast). - March 5, 6, 8, 9, 18, 19, 20, 22, 24 and 27 (lunch). - April 1, 5, 11, 12, 13 and 15 (lunch). - April 19, 21, 24, 25 and 26 (dinner). - May 8, 10, 14, 17, 19 and 22 (dinner). B. E20 held Lantus insulin 3 times (May 1, 9 and 17) with R110's blood sugar ranging from 138 to 224. This medication was ordered without a parameter for holding the administration. During an interview with E4 (LPN, UM) on 5/24/17 around 9:00 AM E4 printed the "Medication Administration" and 'Hypoglycemia" policies which were immediately reviewed: - 7/8/16: "Hypoglycemia" policy included the procedure that if a blood sugar was 60 or less to treat for hypoglycemia. - 2/1/17: "Medication Administration" included the procedure ..."If withholding a medication, record the reason for withholding it in the nurses' notes and follow the organization's practice for noting withheld doses." During an interview with E4 on 5/24/17 around	F 309	for three consecutive audits. Then the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. B. Resident 47 1. R47 was not negatively affected by the cited deficient practice. The physician was contacted to clarify the order utilizing the numeric or behavioral pain scale to identify the appropriate pain medication to administer. 2. All residents who have various pain medications ordered have the potential to be affected by the cited deficient practice. Future residents will be protected from the cited deficient practice by taking the corrective actions outlined below in #3. 3. The facility will conduct a focused review of all like residents who have more than one medication ordered for the treatment of pain. The DON/designee will educate licensed nurses on the the adherence to ordered medication parameters and utilization of the numeric or behavioral pain scale. 4. The DON/designee will audit all residents with an order for more than one pain medication. The audit will be conducted daily until 100% compliance is achieved. The audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then the audits will be conducted weekly	

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F 309	Continued From page 21 9:10 AM E4 acknowledged that when a medication was held when parameters to hold were not met, the expectation would be to inform the physician and write a [progress/nurses'] note. E4 confirmed that numerous insulin doses were not given to R110 even though the criteria for withholding the medication was not met and said s/he would "clarify with the physician" due in today. E4 stated there was canned text in the computer for notifying the physician when the blood sugar was "under 60." The surveyor pointed out that this conflicted with the "Hypoglycemia" policy which used "60 or less" as criteria for treating low blood sugar; and that R110's blood sugar was 60 on the following dates between February 2017 - May 2017 without evidence the hypoglycemia was treated. - February 4, 5, 6, 10, 24 and 28 (breakfast). - February 26 (dinner). - March 4, 6, 9, 18 and 30 (breakfast). - April 15 and 23 (breakfast). - April 13 (lunch). - May 17 (breakfast). At 11:55 AM on 5/24/17 E4 informed the surveyor the physician changed the parameter for holding the mealtime insulin to hold if blood sugar was under 100 and would not be reliant on meal intake. E4 said that the issue with the Hypoglycemia policy and order entry in the computer was discussed with E11 (Corporate Nurse) since resolution would be at the corporate level. 2. Pain Management The pain management standards were approved by the American Geriatrics Society in April 2002 included: appropriate assessment and management of pain; assessment in a way that	F 309	until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	

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F 309	Continued From page 22 facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. Review of R47's clinical record revealed: 12/9/15 - Admission for therapy after a broken hip. 12/9/15 - Care plan problem for potential for pain related to right hip repair (last reviewed 5/10/17) had the goal that pain will be controlled to a level that is comfortable to resident. Interventions included administer pain medications as ordered and report effectiveness; and assess for acceptable level of pain every shift, monitor for non-verbal signs and symptoms of discomfort. Physicians' orders included PRN two medications for pain: - 1/13/16: Tylenol every 6 hours PRN. - 12/13/16: Oxycodone three times a day PRN. 5/1/17 - Quarterly MDS Assessment documented R47 received PRN pain medication. Review of facility policy entitled "Pain Management Guidelines" (last revised June, 2014) included: - The numeric pain scale or the behavioral observation pain scale can be used to determine the level of pain the resident is experiencing. - For resident receiving PRN medication, the resident's self-description (by verbal or behavioral scale) of the level of pain being experienced will be recorded. The same scale will be used to	F 309		

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	085048	A. BUILDING _____ B. WING _____	05/26/2017

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F 309	Continued From page 23 record the effectiveness of the pain relief intervention. - The use of PRN/breakthrough medication should also be evaluated periodically to allow for adjustment in the routine medication. March 2017 - May 2017 - Review of eMARs and progress (nurses') notes discovered the facility failed to indicate the pain severity using the pain scale assessment before and/or after PRN oxycodone medication on 6 out of 10 administrations: - No pain scale before: March 3; April 30. - No pain scale before and after: March 23; April 1 and 8; May 10. During an interview with E4 (LPN, UM) on 5/24/17 at 9:20 AM E4 reviewed and confirmed the missing assessments then immediately edited the order in the eMAR to add the entry for pain scale assessment before and after administration. E4 said that those entries were "not clicked" when the original order was entered. Surveyor discussed that for a pain rating of 3 it was noted that sometimes Tylenol was given and other times oxycodone was administered. E4 said, "We had been looking at that" and planned to discuss with the physician. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/26/17 at 11:00 AM.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		7/10/17

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F 312	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that one (R56) out of 41 sampled residents did not receive the assistance needed to maintain good personal hygiene for fingernail care. Findings include: 12/1/16 - physicians' orders included nail care with showers, twice a week. [This is a CNA task.] 5/9/17 - MDS assessment documented R56 required extensive assistance with personal hygiene. Observations of R56's hands were made on 5/18/17 at 2:10 PM, 5/24/17 at 2:32 PM and 5/25/17 at 11:02 AM found unclean, untrimmed, jagged fingernails. During an interview on 5/25/17 at 11:30 AM, E19 (CNA) explained that "nail care" means staff clean under the resident's fingernails, using tools they have been provided with. They do not clip a resident's fingernails unless they receive specific directions to do so, because a resident may have a diagnosis making nail clipping a hazard. During an interview on 5/25/17 at 11:34 AM, E18 (RN, UM) was briefed on the details of the observations and the interview with E19 and confirmed that there was "no excuse" for R56's fingernails to be in this condition. These findings were reviewed with E1 (NHA), E2 (DON) and E3 (ADON) on 5/26/17 at 11:00 AM.	F 312	F312 1. R56 was not negatively affected by the cited deficient practice. 2. All residents on the Scott Unit scheduled nail care with showers have the potential to be affected by the cited deficient practice. Future residents will be protected from the cited deficient practice by taking the corrective actions outlined below in #3. 3. The facility will conduct a focused review of all like residents who have nail care ordered with showers. The DON/designee will educate nursing staff on that unit to provide nail care as ordered on shower days. 4. The DON/designee will audit all residents with an order for nail care to be provided on shower days. The audit will be conducted daily until 100% compliance is achieved. The audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		7/10/17

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F 441	Continued From page 25 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		

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F 441	Continued From page 26 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on random observation, the facility failed to ensure resident care equipment was properly cleaned during blood glucose monitoring[R238] for one out of 41 sampled residents, and failed to ensure resident TB (tuberculosis) testing was completed for one (R227) out of 41 sampled residents. Findings Include: 1. The facility policy entitled "Blood Glucose Monitoring" last updated 10/2015 stated that the blood glucose monitoring machine (glucometer) was to be cleaned and disinfected using	F 441	F441 A. Resident 238 1. R238 was not negatively affected by the cited deficient practice. 2. All residents that are ordered blood glucose monitoring have the potential to be affected by the cited deficient practice. Future residents will be protected from the cited deficient practice by taking the corrective actions outline below in #3. 3. The facility will conduct a focused review of all like residents who are	

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F 441	Continued From page 27 disinfectant wipes before and after use. During a medication administration observation on 5/22/17 at 8:49 AM with E25 (LPN) the glucometer was removed from the case and used on R238 to check the blood glucose, then placed on top of the medication cart. E25 did not clean the glucometer before or after use. E25 then transported R238 to her room returned to the medication cart with glucometer still on top. E25 then reported she would be administering medications to another resident. This surveyor confirmed E25 was done with R238's administration. When asked E25 if there were disinfectant wipes on the medication cart; E25 began to look through the cart, upon visual inspection found no wipes on the cart. Surveyor asked if E25 typically cleaned the glucometer between uses, E25 stated yes then went to get disinfectant wipes and cleaned glucometer. 2. R227 was admitted to the facility on 4/8/17. A first step PPD (TB skin test) was administered on admission but was never read until 48 to 72 hours after the test. The resident did have a second step PPD on 4/15/17 that was negative. An interview on 5/24/17 with E2 (DON) confirmed these findings. These findings were reviewed with E1 (NHA), E2 and E3 (ADON) on 5/26/17 at 11:00 AM.	F 441	diabetic and have blood glucose monitoring ordered to determine that no other resident was negatively affected by the cited deficient practice. The DON/designee will educate licensed nurses on the facility policy of cleaning and disinfecting of the blood glucose monitoring machine. 4. The DON/designee will audit the cleaning and disinfecting of the blood glucose monitoring machine. The audit will be conducted daily until 100% compliance is achieved. The audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting. B. Resident 227 1. R227 was not negatively affected by the cited deficient practice. 2. All residents that are admitted to the facility have the potential to be affected by the cited deficient practice. Future residents will be protected from the cited deficient practice by taking the corrective actions outline below in #3. 3. The facility will conduct a focused review of all like residents who were admitted onto the Scott unit in the past 30 days to verify the reading of the PPD tests were timely. The DON/designee will educate licensed nurses on the facility	

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F 441	Continued From page 28	F 441	policy of reading and documenting the outcome of the PPD test of new admissions. 4. The DON/designee will audit the reading and documentation of the PPD tests in a timely manner. The audit will be conducted daily until 100% compliance is achieved. The audit will be conducted three times a week until 100% compliance is achieved for three consecutive audits. Then the audits will be conducted weekly until 100% compliance is achieved over three consecutive audits. Then another audit will be conducted in one month. If 100% compliance is achieved, the deficiency will be considered resolved. Results of the audits will be presented and discussed at the facility QA Meeting.	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Cadia Rehabilitation Capitol

DATE SURVEY COMPLETED: May 26, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced annual and complaint survey was conducted at this facility from May 18, 2017 through May 26, 2017. The deficiencies contained in this report are based on observation, interviews, and review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was one hundred twelve (112). The survey sample totaled forty one (41).	Our Plan is to Cross Reference CMS 2567-L survey completed May 26, 2017, regarding F241, F242, F244, F248, F272, F3409, F312, and F441.	7/10/17
3201	**Regulations for Skilled and Intermediate Care Facilities**		
3201.1.0	**Scope**		
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey completed May 26, 2017: F241, F242, F244, F248, F272, F309, F312, and F441.		

Provider's Signature Lucy Hallagin Title Administrator Date 6/29/17